

# Oceania Care Company Limited - Duart Rest Home

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## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

**Legal entity:** Oceania Care Company Limited

**Premises audited:** Duart Rest Home

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 11 June 2021 End date: 11 June 2021

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 61

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Duart Rest Home (Duart) is part of the Oceania Care Company Limited (Oceania) group. The service is certified to provide rest home and hospital services (including long-term support for chronic health conditions), restore in aged residential care services (rehabilitation), and mental health in aged care for up to 66 residents. On the day of audit there were 61 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Services Standards and the contract with the district health board (DHB). The audit process included a review of policies and procedures, review of resident and staff files, observations, and interviews with residents, family/whānau, management, and staff.

The previous shortfalls around complaints management and planned activities for residents under the age of 65 have been addressed. No further areas for improvement were identified during the surveillance audit.


## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information regarding the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code), the complaints process, and the nationwide Health and Disability Advocacy Service is accessible. This information is brought to the attention of residents and their families/whānau on admission to the facility. The rights of the resident and/or their family/whānau to make a complaint is understood, respected, and upheld by the service. Residents and their families/whānau confirmed that their rights are being met, staff are respectful of their needs, and communication is appropriate.

The business and care manager (BCM) is responsible for the management of complaints. A complaints register is maintained and up to date. Complaints processes are documented and resolved in a timely fashion.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Oceania is the overarching governing body and it is responsible for the services provided at Duart Rest Home. A business plan and quality and risk management systems document the scope, direction, goals, values, and mission statement of the facility.

The facility has an incident and accident management system that records and reports all adverse, unplanned, or untoward events, including appropriate statutory and regulatory reporting.

The quality and risk management system supports the provision of clinical care at the service. Systems are in place for monitoring adverse events and service quality. Quality and risk performance is reported through meetings at the facility and monitored by the Oceania executive management team through business status and clinical indicator reports. Corrective action plans are documented with evidence of resolution of identified issues.

Services are planned, coordinated, and are appropriate to the needs of the residents. The service is managed by a Business and Care Manager who is supported in their role by a clinical manager. The clinical manager is responsible for the oversight of the clinical service provision in the facility. Staffing levels are adequate across the service. Staff spoke positively about the

support/direction and management of the current management team. Human resource policies are current and implemented. Registered nurses are on duty 24 hours a day and are supported by adequate levels of care and allied health staff. On-call arrangements for support from senior staff are in place.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. And a process for ongoing education and training for staff is documented and being implemented. The staffing levels meet contractual requirements. Registered nursing cover is provided 24 hours a day, seven days a week.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and emergency evacuation plan. There have been no building modifications since the last audit and there is a reactive and planned maintenance programme in place. Electrical and biomedical equipment has been tested as required. Water temperatures are monitored with discrepancies outside normal limits addressed. Lifts have been serviced as per schedule.

There is sufficient space to allow the movement of residents around the facility using mobility aids. The outdoor areas are well-maintained, safe and easily accessible.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Duart Rest Home has implemented policies and procedures that support the minimisation of restraint and safe practice. One enabler and two restraints were in use on the day of audit. Restraint is only used as a last resort when all other options have been explored. Enabler use is voluntary for the safety of residents in response to individual requests. Staff receive training at orientation/induction and annually on restraint minimisation and the management of difficult challenging behaviours. Staff interviewed demonstrated an understanding of the restraint and enabler processes and the differences between them.

## Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation's complaints policy and procedures are in line with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and include timeframes for responding to a complaint. Complaint forms were observed to be available in the facility and one family member of a resident advised that she was given information on the complaints process when her family member was admitted to the facility. Some of the other residents and family/whānau interviewed reported that, while they were not sure where complaints forms were kept, they felt confident that they would know how to make a complaint in the event that they needed to.</p> <p>The complaints register reviewed showed that there have been 16 complaints since May 2020 and, apart from one received two days before the audit, all had been appropriately addressed within reasonable timeframes. There is a process that outlines the management of complaints including access to advocacy and escalation pathways. The BCM is responsible for complaints management and follow up.</p> <p>Six staff were interviewed during the audit, the CM, three RNs, and two HCAs. They confirmed an understanding of the complaints and open disclosure processes and the actions required if a resident or their family/whānau wanted to make a complaint. There have been no complaints received from external sources since the previous audit.</p>



<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy that sets out the process to guide staff and ensure that there is open disclosure of any adverse event where a resident has suffered unintended harm while receiving care. Six completed incident forms (three falls and three skin tears) were reviewed, all demonstrated that family/whānau are informed if the resident has an incident/accident, or a change in health. Five residents and four family/whānau were interviewed during the audit. Residents and their family/whānau confirmed that they provide input into the care planning process. The resident admission agreements are signed by the resident or enduring power of attorney (EPOA).</p> <p>There are two-monthly residents' meetings to inform residents of facility events and activities and provide attendees with an opportunity to make suggestions, provide feedback; and to raise and discuss any issues. Minutes sighted confirmed that residents had the opportunity to raise any issues and have them addressed.</p> <p>Resident and family interviews confirmed that the BCM, the CM, and other staff are approachable and available to discuss queries and issues. Interviews with residents and families/whānau identified that the BCM addresses queries promptly.</p> <p>Interpreter services were available as required through the DHB, there were no residents who required interpreter assistance on the day of the audit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Duart is part of the Oceania group. The company's executive management team provide support to the facility and have access to Duart business and quality information. The business plan is reviewed annually and outlines the purpose, values, scope, direction and goals of the organisation. The document described the annual and longer-term objectives and progress against the plan is reported to the Oceania executive and at the Duart internal quality improvement, registered nurses, and staff meetings.</p> <p>The service is managed by a BCM who holds relevant qualifications and has been in the role for one year. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The BCM is supported by an aged-care experienced CM who has been employed at Duart for five years and is a registered nurse with a current practising certificate. The BCM and CM confirmed knowledge of the sector, regulatory, and reporting requirements and they maintain currency through engagement with other Oceania facilities and through the DHB.</p> <p>The service holds contracts with the DHB for aged-residential care, long-term chronic health conditions (under 65), restore (rehabilitation) in aged residential care services, and mental health in aged residential care. On the day of audit there were 61 residents; 57 residents were receiving services under the aged-residential care contract and four under the long-term chronic health conditions contract.</p>
<p>Standard 1.2.3: Quality</p>	<p>FA</p>	<p>The service implements organisational policies and procedures to support service delivery. All policies have</p>

<p>And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>evidence of timely review and are current. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. The BCM was familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Policies are available to staff and staff are informed of new and revised policies, through staff meetings.</p> <p>Duart uses Oceania’s documented quality and risk management framework to guide their practice. There are processes in place for the facility to implement the quality and risk management system which monitors key components of service delivery and reflects the principles of continuous quality improvement. Reporting systems demonstrate the collection, collation, and analysis of data, and the identification of trends. This includes the management of incidents/accidents/hazards, complaints, audit activities, an annual family/whānau satisfaction survey, monitoring of outcomes, and clinical incidents including infections. An internal audit schedule is implemented, and results are communicated to staff.</p> <p>The facility has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence that hazard identification forms are completed when a hazard is identified and that hazards are addressed, and risks minimised or isolated.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality improvement, registered nurses and at staff meetings. Staff reported their involvement in quality and risk management activities through their meetings with the management team. Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>The 2020 resident and family/whānau satisfaction survey showed that residents and their families/whānau were positive about the service and this was confirmed through resident and family/whānau interviews.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and ‘near miss’ events on an electronic resident management system. Over the past year, there has been an average of 11 incidents per month, primarily falls (with one frequent faller), or falls with minor injury (e.g. skin tear). A sample of six incidents reviewed showed that actions in respect of these were fully completed, incidents were investigated and openly disclosed to family/whānau as appropriate, action plans were developed, and followed-up in a timely manner. Adverse event data is collated, analysed and reported at quality improvement, registered nurses (RN) and staff meetings. Incident reports selected for review had corresponding notes in the clinical record to inform staff of the incident. Information gathered is regularly shared at facility meetings with incidents graphed, trends analysed, and benchmarking of data across other Oceania facilities.</p> <p>The BCM and CM confirmed an understanding and awareness of the circumstances and events that require the facility to report to and notify statutory authorities, including police attending the facility, unexpected deaths, critical incidents (including pressure injuries), and infectious disease outbreaks. They advised there has been two notifications of a significant event (unstageable pressure injuries) to the Ministry of Health, both now closed.</p> <p>Staff records reviewed demonstrate that staff receive education during orientation on the adverse events reporting</p>

		<p>process. Staff interviewed confirmed understanding of the adverse event reporting process and their obligation to documenting all untoward events.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting, and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. The skills and knowledge required for each position are documented in job descriptions.</p> <p>Seven staff files reviewed (one CM, one RN, one enrolled nurse (EN), two health care assistants (HCA), one chef, and one cleaner/kitchen assistant) demonstrated that recruitment processes for all staff include: reference checks; a signed employment agreement; specific job description; and police vetting. There is a system to ensure that annual practising certificates (APCs) are current including those for RNs, ENs the GP, pharmacist; podiatrist, and physiotherapist.</p> <p>Staff orientation includes all necessary components relevant to the role. It requires new staff to demonstrate competency on a number of operational and care related tasks and staff reported that the orientation process prepared them for their role. Competencies such as first aid; interRAI; medication; manual handling and hand hygiene are reviewed and assessed annually. Staff records reviewed showed documentation of completed orientation and a performance review on an annual basis.</p> <p>Continuing education is planned on a biannual basis, including mandatory training requirements. A review of the management system confirmed that processes are in place to ensure that all staff complete their required training and competencies and staff have undertaken a minimum of eight hours of relevant training, including training on open disclosure. There are 10 RNs, including the care manager who have completed and maintained the annual interRAI competency requirements to undertake interRAI assessments.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Staffing levels are reviewed for current and anticipated workloads. There is a roster that aligns with contractual requirements and includes skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). At least one RN is present in the facility at all times and there is RN and/or CM on-call support available.</p> <p>Rosters reviewed reflected that staffing levels meet resident acuity, bed occupancy and the staffing requirements as per contract in relation to the level of care required. The CM has authority to increase staffing levels based on acuity and the changing needs of residents. There is a process in place to source additional staff in periods of unplanned absences. Most of the care staff reported there were adequate staff available to complete the work allocated to them, one said that they often worked short staff but this was not borne out following review of the rosters. Evidence was sighted to show that staff had been replaced where there were unplanned absences, either</p>

		<p>by Duart staff or by agency staff. Staffing levels appropriateness was supported by the family/whānau interviewed, they confirmed that staffing numbers were good and sufficient to meet resident needs.</p> <p>There are two RNs and one EN (this is an RN over the weekend) on morning shift (8 hours shifts) who work with the support of eight HCAs (3 x 8 hour shifts, one x 7.5 hours, 3 x 6.5 hours and one x 4.25 hours). In the afternoon there are two RNs Monday to Friday and three on Saturday and Sunday (8 hour shifts). They work with the support of eight HCAs Monday to Friday and seven on Saturday and Sunday (1 x 8 hour shift, 1 x 7.5 hours, 2 x 6.5 hours, 1 x 5.5 hours, 1 x 5 hours, 1 x 4.5 hours, and 1 x 4 hours). There is one RN and three (8 hour) HCA shifts on night duty. The BCM and CM work 40 hours per week Monday to Friday and there is another RN and/or CM on call out of hours and at weekends. Staff reported that good access to advice is available to them when needed. Observations and review of two 4-week roster cycles confirmed adequate staff cover has been provided. At least one staff member on duty on each shift has a current first aid certificate.</p> <p>The diversional therapist (DT) works Monday to Friday, 6.5 hours per day and the facility is currently recruiting for a weekend activities coordinator or diversional therapist.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. There are three medication rooms in the facility that all had recordings of fridge and room temperatures within the required range.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>All the controlled drugs are stored appropriately in the hospital wing in two safes, one for rest home and one for hospital level residents. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used. The GP confirmed the use of an electronic system has made verbal orders obsolete.</p> <p>There are no residents who were self-administering medications at the time of audit. There is an appropriate and</p>

		<p>safe system in place should a resident wish to self-administer their own medications.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by two qualified chefs and a kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (31 March 2021). Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Ministry for Primary Industries and is current until 22 March 2022. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents are advised of the menu on a daily basis and have the option of completing a request form for an alternative if they wish within a time frame suitable to the kitchen. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a dignified manner.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations, and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation and that they were informed of changes to a residents' condition at handovers. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs such as air mattresses and sensor mats.</p>
<p>Standard 1.3.7: Planned Activities</p>	FA	<p>The activities programme is provided by a trained Diversional Therapist (DT) holding the national Certificate in Diversional Therapy. They work over the weekdays and leave activities for staff to use at weekends. They are currently recruiting for another activities staff member to help with the role. The DT has worked in the facility for a</p>

<p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>number of years and produces an interesting programme that the residents confirmed was stimulating and varied.</p> <p>A social assessment and life history is undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated by observing resident engagement and as part of the formal six-monthly care plan review. Progress is documented in the resident files of goals achieved and participation recorded.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings. For the four residents who were under the age of 65 years there were age appropriate activities and coffee outings. Family members are involved in helping these residents meet their social needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Evidence was sighted of care plans being updated to reflect changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for urinary tract infections, and wounds. When necessary, and for unresolved problems, long-term care plans are added to and updated, this was demonstrated in the case of a chronic wound. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There is a current building warrant of fitness displayed in the entrance of the facility expiring 17 January 2022. The BCM stated there have not been any alterations to the building since the last audit. All biomedical and electrical equipment was recently serviced and/or calibrated (January 2021). Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plan. Hot water temperatures are monitored monthly with variances addressed (evidenced).</p> <p>The service has a dedicated single story rest home and a two-storey rest home/hospital complex with lift access. Lifts have been serviced and maintained. There are multiple lounge and dining areas located throughout the facility including areas that allow for resident and family/whānau privacy.</p> <p>The facility has sufficient space for residents to mobilise using mobility aids. Residents have access to well-maintained external areas.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long-term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The RN on duty is responsible for entering the infection into the infection register and this data is collated monthly and analysed to identify trends, possible causative factors and required actions. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the facility manager and quality team, and displayed in the staff room. Data is benchmarked externally within the group. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>There were no reports of outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Oceania restraint minimisation and safe practice policies and procedures comply with legislative requirements. The restraint coordinator provides support and oversight for enabler and restraint management in the facility. The restraint coordinator was not available on the day of the audit. The CM interviewed demonstrated a sound understanding of the organisation's policies, procedures and practice. The job description for the restraint coordinator was reviewed and was appropriate for the roll.</p> <p>The restraint register is maintained, and assessments and reviews evidenced. Restraints are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Enablers are voluntary, and the least restrictive option is in use to maintain resident independence and safety.</p> <p>There were two residents using restraints and one resident using an enabler (personally requested) at the time of the on-site audit. Interviews with staff confirmed enabler use is voluntary and they were able to explain the difference between an enabler and a restraint. Restraint minimisation and safe practice education is provided to all staff at orientation/induction to the service and ongoing education is provided to staff annually. This was confirmed through training records and during interviews with staff.</p>

## Specific results for criterion where corrective actions are required

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Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
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End of the report.